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Washington State Department of Social & Health Services

Fact Sheet:

How Washington State's Medicaid Nursing Home Rate is Set

In Washington, Medicaid rates are set individually for each nursing facility. Rates are based generally on

- a facility's costs,
- a facility's occupancy level, and
- the individual care needs of a facility's residents.

The Medicaid payment rate system does not guarantee that all allowable costs relating to the care of Medicaid residents will be fully reimbursed.

The Medicaid rate for a facility is comprised of seven separate components**:**

- **direct care** – nursing and other related care provided to residents (54.88% of total rate)
- **therapy care** – speech, physical, occupational, and other therapy (.44% of total rate)
- **support services** –food and dietary services, housekeeping, and laundry (14.46% of total rate)
- **operations** – administration, utilities, accounting, and maintenance (20.03% of total rate)
- **variable return** – an incentive payment for relative efficiency (2.11% of total rate)
- **property** – depreciation allowance for real property improvements, equipment and personal property used for resident care (3.55% of total rate)
- **financing allowance** – return on the facility's net invested funds (the value of its tangible fixed assets and allowable cost of land) (4.54% of total rate.)

Component rates are based on adjusted costs from each facility's **cost report.** Component rates for 7/1/2001 through 6/30/2006 for *direct care, therapy care, support services, operations,* and *variable return* are based on 1999 cost reports inflated annually by legislative mandated economic trends and conditions factors defined in the biennial appropriations act. Property and financing allowance components are rebased annually.

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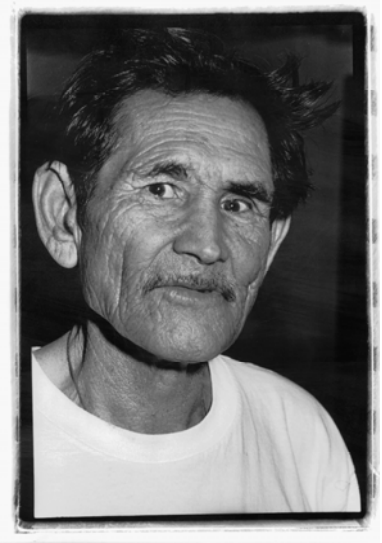
The primary goal is to pay for nursing care rendered to Medicaid-eligible residents in accordance with federal and state laws.

Medicaid nursing facility rates are set by the Nursing Home Rates Section of the Office of Rates Management (ORM), Aging and Disability Services Administration (ADSA), Department of Social and Health Services (DSHS).



The Legislature sets a maximum average daily rate in the budget. For FY06 that maximum is $149.14.

The Direct Care rate is adjusted quarterly to account for changes in resident acuity.

Case mix principles are used to set all facilities' direct care component rate. Facilities are required to assess individual residents. With this data, the Office of Rates Management (ORM) determines for each facility both a facility average case mix index (for all residents) and a Medicaid average case mix index (for Medicaid residents only). The case mix index indicates the intensity of need for services by the residents.

ORM is required to array direct care costs per case mix unit separately for three **peer groups** of nursing facilities, depending on their location in 1) high labor cost counties – currently, only King County, 2) urban counties – those in a "metropolitan statistical area" (MSA) as defined by the federal government, and 3) nonurban counties – those not in an MSA.

The **median** cost per case mix unit of each peer group – i.e., the point at which half of the facilities are above, and half below - is then determined. A facility's direct care cost per case mix unit is adjusted, if necessary, to bring it within a **corridor -** i.e., up to a floor of 90%, or down to a ceiling of 110%, of the facility's peer group median cost per case mix unit. A facility's direct care component rate is equal to its allowable direct care cost per case mix unit from its 1999 cost report, multiplied by its Medicaid average case mix index from the applicable quarter. Direct care component rates are updated effective the first day of each calendar quarter, to reflect changes in a facility's case mix. The resident assessment date used for each update is taken from the calendar quarter commencing six months, and ending three months, prior to the effective date of the quarterly update.

The rates for various other components are also subject to corridors or lids:

For example, in establishing the **therapy care** component rate, ORM separately arrays one-on-one and consulting costs for each of the four types of therapy, both for urban and non-urban counties. Each facility's allowable costs for each category are **lidded** – i.e., set at either the facility's actual cost or 110% of the applicable median.

The **support services** and **operations** component rates are based on a facility's allowable costs, subject to median lids. The lid in support services is set at 110% of the median costs for all facilities in a peer group. The lid in operations is set at the median cost.

The Property and Financing Allowance components are recalculated annually.

The **property** component rate reflects allowable depreciation expense for assets used to provide patient care. The **financing allowance** component rate is calculated by multiplying the net invested funds of each facility by 8.5%.

The Variable Return

The **variable return** component rate is an incentive to encourage cost efficiency. ORM ranks all Medicaid facilities according to each facility's 1999 total combined and adjusted direct care, therapy care, support services, and operations costs. One ranking from highest to lowest is done, without regard to peer groups, and costs are not reduced by the limits based on median costs. The ranking is divided into four quartiles, each containing as nearly as possible the same number of facilities. A percentage is then assigned to each quartile - 1% to the highest (i.e., the highest-cost quartile), 2% to the next, 3% to the next, and 4% to the lowest. The applicable percentage is multiplied by each facility's combined per resident day component rates in direct care, therapy care, support services, and operations to derive its variable return component rate.

Direct Care, Therapy Care, Support Services and Operations are adjusted annually for any vendor rate increases approved by the legislature.

Resident Days

To set all component rates, the number of **resident days** – the total days eligible residents resided at the facility for the applicable report period -- is used. Resident days are divided into allowable costs for the period to express facility costs as per resident day amounts.

Resident days are subject to **minimum occupancy** levels. If resident days are below the minimum, they are increased to the imputed occupancy level, which has the effect of reducing per resident day costs and the component rates based on such costs. If the actual occupancy level is higher than the minimum, the actual number of resident days is used.

Effective July 1, 2002, the minimum occupancy for direct care, therapy care, support services and variable return component rates is 85%; for operations, financing allowance, and property component rates, the minimum occupancy is 90%. However, for **essential community providers** – i.e., facilities at least a forty minute drive from the next closest nursing facility – the minimum occupancy is set at 85% for all components, in recognition of their location in lesser-served areas of the state.

Facilities may engage in bed banking by temporarily reducing the number of patient beds for which they are licensed.

This option, which can result in an upward revision of component rates, is offered to facilities to discourage an over-supply of licensed beds in the state, which would make the entire system less efficient. When beds are **unbanked** – i.e., returned to licensed status – component rates may be subject to downward revision, if indicated. If a facility's affected component rates are revised upward or downward, such revision is made prospectively, effective as of the date licensed bed capacity is increased or reduced.

The Settlement Process

In a process called **settlement**, direct care, therapy care, and support services component rates are compared to each facility's expenditures in those categories for each report period. A facility must return to DSHS all unspent rate payments in those three categories. However, if a facility has provided exemplary care and has not received any major survey findings during the year, the facility may retain up to 1% above their component rate, weighted by Medicaid resident days, for the report period.

The Budget Dial

Finally, over and above all, the rate setting methodologies provided in both the statutes and regulations, there is the **budget dial** imposed by RCW 74.46.421. In the biennial appropriations act, the legislature sets a statewide weighted average maximum nursing facility payment rate for each state fiscal year (SFY). For example, for SFY 2006, the budget dial is set at $149.14 per resident day. The department is not mandated to pay rates equal to the maximum allowed by the legislature. To the contrary, the department is required to maintain rates consistent with very specific laws and regulations that offer little, if any flexibility. By statute, DSHS is required to reduce rates for all Medicaid participating nursing facilities statewide by a uniform percentage, after notice and on a prospective basis only, if the statewide average facility total rate approaches these limits. The budget dial ensures that total Medicaid nursing facility spending does not exceed the amount appropriated by the legislature.